

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03948

3958

CERTIFICATE OF DEATH

Reg. Dist. No.

96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY Suffolk	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville, Rural		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Canvas Back Inn		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patchogue, Long Island, N.Y.	
3. NAME OF DECEASED (Type or print) John Cooper Barrie		4. DATE OF DEATH April 26 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 18, 1878
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Dealer		10b. KIND OF BUSINESS OR INDUSTRY Owner	
11. BIRTHPLACE (State or foreign country) Scotland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Barrie		14. MOTHER'S MAIDEN NAME Annie M. Cooper	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Anna H. Barrie,		287 South Ocean Ave., Patchogue, L.I., N.Y.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Arterio Sclerosis Cardio Vascular Hypertension Disease Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 23, 1957, to April 26, 1957, that I last saw the deceased alive on April 26, 1957, and that death occurred at 3:30 A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles J. Foley M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 4/26/57	
PHYSICIAN'S NAME (Type) Charles J. Foley, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-29-1957	
22c. NAME OF CEMETERY OR CREMATORY Cedar Grove		22d. LOCATION (City, town, or county) (State) Patchogue, N.Y.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son,		ADDRESS Perryville, Md.	
24a. REC'D BY REGISTRAR DATE 4-26-57		24b. REGISTRAR'S SIGNATURE Irene E. Daugherty	

HEALTH-BATHING 18

DEATH

BUREAU V. S.

APR 30 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

03949
96

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen 12x22 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS Route #1, Bush Chapel Road	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle (NMI) Last BOYD		4. DATE OF DEATH Month April Day 18 Year 19 57	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-26-19
9. AGE (In years lost birthday) 38 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Arkansas		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Boyd - Deceased		14. MOTHER'S MAIDEN NAME Elizabeth (?) - Deceased	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 181x Carcinoma of the urinary bladder Grade IV with DUE TO widespread abdominal metastases to the bones & lungs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pyelonephritis, left, severe DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Unknown Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 28, 1956, to April 18, 1957, and that death occurred at 9:40 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Opler		ADDRESS (Street, city or town, state) DATE SIGNED V.A. Hospital, Perry Point, Md. 4-18-57	
PHYSICIAN'S NAME (Type) W. OPLER		Director, Professional Services	
22a. BURIAL, CREMATION, or other disposal (Specify) 4-18-57		22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary	
22d. LOCATION (City, town, or county) (State) Aberdeen, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Harre de Grace, Md.		24a. REC'D BY REGISTRAR DATE 4-20-57	
24b. REGISTRAR'S SIGNATURE Irene E. Daugherty			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

03950

96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit, Rural		c. LENGTH OF STAY IN 1b 42 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harmony Chapel Road		d. STREET ADDRESS / Harmony Chapel Rd.	
3. NAME OF DECEASED (Type or print) First Eva Middle May Last Burlin		4. DATE OF DEATH Month April Day 23 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 2, 1883
9. AGE (In years last birthday) 75		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David		14. MOTHER'S MAIDEN NAME Mary R. Gray	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. [If yes, give war or dates of service]	
17. INFORMANT Address W. James Burlin, Perryville, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cerebral Hemorrhage - DUE TO (b) Hypertension DUE TO (c) Arterio-Sclerosis - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocarditis -			INTERVAL BETWEEN ONSET AND DEATH 1 hour. 8 yrs - 8 yrs -
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August, 1954, to April 22, 1957, that I last saw the deceased alive on April 22, 1957, and that death occurred at 4:55 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Clarence I. Benson		DATE SIGNED April 24, 1957	
PHYSICIAN'S NAME (Type) Clarence I. Benson, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-26-1957	
22c. NAME OF CEMETERY OR CREMATORY Hopewell		22d. LOCATION (City, town, or county) (State) Port Deposit, Md. Rural	
23. FUNERAL DIRECTOR'S SIGNATURE Address L. A. Patterson & Son, Perryville, Md.		24a. REC'D BY REGISTRAR DATE 4-25-57	
		24b. REGISTRAR'S SIGNATURE Irene E. Dougherty	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		OCCUPATION	
JAMES H. HARRIS		Male		65		1892		Maryland		Farmer	
MARRIED		Wife		62		1890		Maryland		Homemaker	
EDUCATION		Grade		High School		Grade		High School		Grade	
RELIGION		Methodist		Methodist		Methodist		Methodist		Methodist	
CAUSE OF DEATH		Heart Disease		Heart Disease		Heart Disease		Heart Disease		Heart Disease	
MANNER OF DEATH		Natural		Natural		Natural		Natural		Natural	
PLACE OF DEATH		Home		Home		Home		Home		Home	
DATE OF DEATH		April 28, 1957		April 28, 1957		April 28, 1957		April 28, 1957		April 28, 1957	
TIME OF DEATH		10:30 AM		10:30 AM		10:30 AM		10:30 AM		10:30 AM	
SIGNATURE OF PHYSICIAN		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
SIGNATURE OF REGISTRAR		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	

BUREAU V. S.

APR 29 1957

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3946

CERTIFICATE OF DEATH

03951

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 10 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Isaac Middle Campbell Last Campbell		4. DATE OF DEATH Month 4 Day 15 Year 19 57	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-1- 1888
9. AGE (In years last birthday) yrs. 69		IF UNDER 1 YEAR Months 69 Days 15 Hours 19 Min. 57	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Day	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Richard Campbell	
14. MOTHER'S MAIDEN NAME Sallie Wilson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 2-18-05-6810		17. INFORMANT Nellie Griffin, Race St., Port Deposit, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardio-vascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 422.1 DUE TO (c) 422.1		INTERVAL BETWEEN ONSET AND DEATH unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia, right lower lobe, cause undetermined		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 4 , 19 57 , to April 14 , 19 57 , that I last saw the deceased alive on April 14 , 19 57 , and that death occurred at 2:50 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE S. Ralph Andrews, Jr.		ADDRESS (Street, city or town, state) 233 E. Main St., Elkton, Md. DATE SIGNED 4/15/57	
PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 4-17-1957	
22c. NAME OF CEMETERY OR CREMATORY Jones Memorial		22d. LOCATION (City, town, or county) (State) Port Deposit, Md. Rural	
23. FUNERAL DIRECTOR'S SIGNATURE W. A. Patterson & Son		ADDRESS Perryville, Md.	
24a. REC'D BY REGISTRAR DATE 4/17/57		24b. REGISTRAR'S SIGNATURE HR. J. J. J.	

BUREAU V. S.

APR 18 1957

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3961

CERTIFICATE OF DEATH

Reg. Dist. No. 96

03952

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Chesapeake			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point			c. LENGTH OF STAY IN 1b 10 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenburnie 02X22		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALBERT Middle O. Last CASSERLY				4. DATE OF DEATH Month April Day 2 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-31-86		9. AGE (In years lost birthday) 71 yrs. IF UNDER 1 YEAR: Months 7 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchmaker		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas J. Casserly				14. MOTHER'S MAIDEN NAME Elizabeth Winebasner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) WW I		17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia lobar, left lower lobe 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Abscess left lower lobe, staphylococcus aureus DUE TO (c) Approx. 1 week						INTERVAL BETWEEN ONSET AND DEATH 12-14 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 002X Tuberculosis pulmonary, far advanced, inactive - unknown						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 23 , 19 57 , to April 2 , 19 57 , and that death occurred at 12:30p M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 4-3-57							
ACTUAL SIGNATURE W. Oppler				PHYSICIAN'S NAME (Type) W. OPPLER Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 4-3-57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Remington & Son, Havre de Grace, Md.				24a. REC'D BY REGISTRAR DATE 4-5-57		24b. REGISTRAR'S SIGNATURE Irene E. Daugherty	

BUREAU V. S.

APR 8 1957

RECEIVED

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 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03953

3947

CERTIFICATE OF DEATH

Reg. Dist. No.

92

1. PLACE OF DEATH o. COUNTY CECIL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md b. COUNTY CECIL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO NORTH EAST			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION UNION HOSPITAL				d. STREET ADDRESS 1			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First REBECCA Middle J. Last CHURCH				4. DATE OF DEATH Month 4 Day 14 Year 1957			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-14-1887	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) DEEP GAP N.C.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME ALEXANDER CHURCH				14. MOTHER'S MAIDEN NAME LID D			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) - (If yes, give war or dates of service) -				16. SOCIAL SECURITY NO. NONE		17. INFORMANT John C Church North East Md Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hyper-tensive Cardiovascular Renal Disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) - DUE TO (c) -						INTERVAL BETWEEN ONSET AND DEATH 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatoid Arthritis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -			
20c. TIME OF INJURY Month, Day, Year Hour o. m. - p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -	
20f. (City or town) - (County) - (State) -							
21. I certify that I attended the deceased from 8 April, 1957 to 14 April, 1957 , that I last saw the deceased alive on 14 April, 1957 , and that death occurred on 2 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Klaus H. Huebner M.D.				ADDRESS (Street, city or town, state) North East Md DATE SIGNED 14 April 1957			
PHYSICIAN'S NAME (Type) Klaus H. Huebner M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 4-15-1957		22c. NAME OF CEMETERY OR CREMATORY Pattons Ridge		22d. LOCATION (City, town, or county) (State) C. Blair N.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph P. Grant ADDRESS North East Md				24a. REC'D BY REGISTRAR DATE 4/15/57		24b. REGISTRAR'S SIGNATURE J.P. Trager	

3962

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville		c. LENGTH OF STAY IN 1b 41 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Aikin Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Morris		4. DATE OF DEATH April 7 1957	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 31, 1895	
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Conductor		10b. KIND OF BUSINESS OR INDUSTRY Pa. R.R.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Anthony Cole		14. MOTHER'S MAIDEN NAME Angeline Crea	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 717-07-5940	
17. INFORMANT Virgie Cole, Perryville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 181X generalized carcinomatosis DUE TO (b) Carcinoma of bladder DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 1957, to April 7, 1957, that I last saw the deceased alive on April 7, 1957, and that death occurred at 11:30 PM, from the causes and on the date stated above. EDWARD SIMON, M.D. HARRY D. GRACE ACTUAL SIGNATURE DATE SIGNED PHYSICIAN'S NAME (Type) Edward Simon, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-10-1957	
22c. NAME OF CEMETERY OR CREMATORY Asbury		22d. LOCATION (City, town, or county) (State) Port Deposit, Md. Rural	
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son		24a. REC'D BY REGISTRAR DATE 4-8-57	
ADDRESS Perryville, Md.		24b. REGISTRAR'S SIGNATURE Irene E. Daugherty	

VS A15 (4)
15M 9/55

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	
JAMES EARL RAY		Male		35		White		1928		Memphis, Tenn.		April 4, 1968		Nashville, Tenn.		Shot		Suicide		James Earl Ray		James Earl Ray	
13. OCCUPATION		14. EDUCATION		15. RELIGION		16. MARITAL STATUS		17. PREVIOUS ILLNESS		18. PREVIOUS SURGERY		19. PREVIOUS TRAUMA		20. PREVIOUS DRUGS		21. PREVIOUS ALCOHOL		22. PREVIOUS TOBACCO		23. PREVIOUS OTHER		24. PREVIOUS OTHER	
Attorney		High School		Methodist		Single		None		None		None		None		None		None		None		None	
25. SIGNATURE OF WITNESS		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS		28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS		31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS		34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS	
John Doe		Jane Smith		Bob Johnson		Alice Brown		Charlie White		Diana Green		Frank Black		Grace Grey		Henry Gold		Irene Silver		Jack Bronze		Karen Copper	

RECEIVED
 APR 11 1968
 BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3948

CERTIFICATE OF DEATH

Reg. Dist. No. 03955

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton c. LENGTH OF STAY IN 1b 1 week d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last William Evan Craig			4. DATE OF DEATH Month Day Year 4 26 1957				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-28-1884		9. AGE (In years last birthday) yrs. 72		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Fire Brick Co		11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME George Washington Craig				
14. MOTHER'S MAIDEN NAME Elizabeth Ann Sentman			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No				
16. SOCIAL SECURITY NO. 216-05-6576		17. INFORMANT Mrs Wm B. Craig North East, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma floor of mouth with metastasis 143X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) — (c) — PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —					INTERVAL BETWEEN ONSET AND DEATH 9 months		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. — 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 6 July 1956, to 26 April 1957, that I last saw the deceased alive on 26 April 1957, and that death occurred at 7:20 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Klaus H. Huchner		M.D. North East, Md		DATE SIGNED 26 April '57			
PHYSICIAN'S NAME (Type) Klaus H. Huchner M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-29-1957	22c. NAME OF CEMETERY OR CREMATORY Methodist	22d. LOCATION (City, town, or county) (State) North East, Cecil, Md				
23. FUNERAL DIRECTOR'S SIGNATURE Joseph P. Brown		ADDRESS North East, Maryland		24a. REC'D BY REGISTRAR DATE 4/29/57	24b. REGISTRAR'S SIGNATURE J. P. Brown		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3963

03956

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Cecil					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colora R.D.		c. LENGTH OF STAY in 1b All life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Xo Colora					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Annie E Creswell				4. DATE OF DEATH Month 4 Day 14 Year 19 57					
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-8-1872		9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY House work		11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Edward Pierce				14. MOTHER'S MAIDEN NAME Jennie Shank					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Arthur Dinsmore, Rising Sun, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE R.C. Dodson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 4-15-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/17/57		22c. NAME OF CEMETERY OR CREMATORY Brookveiw Cem.		22d. LOCATION (City, town, or county) (State) Rising Sun, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Ralph M Reed				ADDRESS Rising Sun Md		24a. REC'D BY REGISTRAR DATE Apr 16-56		24b. REGISTRAR'S SIGNATURE L.H. Worthington	

RECEIVED

APR 17 1957

BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3949

Reg. Dist. No.

03957
92

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Cecil					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 5 1/2 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East X0					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital				d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Blanchard DeLancey Last				4. DATE OF DEATH Month 4 Day 1 Year 19 57					
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-20-1873			
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Surveyor		10b. KIND OF BUSINESS OR INDUSTRY same		11. BIRTHPLACE (State or foreign country) Perry Co. Pa		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William Power DeLancey				14. MOTHER'S MAIDEN NAME Wolf					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) Spanish Amer 220-34-5553		17. INFORMANT Address Mary Bouchelle, Dover Del.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 916.1 Second and Third degree burns entire DUE TO Conditions, if any, which gave rise to immediate cause (b) body. (a), stating the underlying cause last. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Using flame thrower and clothes caught fire							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 5.15 p. m. 4-1 19 57		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Nat while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm		20f. (City or town) (County) (State) Northeast Cecil Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE R.C. Dodson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) R.C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 4-2-57					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-3-1957		22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery		22d. LOCATION (City, town, or county) (State) Elkton, Cecil Co., Md			
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Shant				ADDRESS North East, Maryland		24a. REC'D BY REGISTRAR DATE 4/3/57			
						24b. REGISTRAR'S SIGNATURE J.R. Frazer			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
PLACE OF DEATH		CITY		COUNTY		STATE		ZIP	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		POLITICAL PARTY	
PREVIOUS ILLNESS		CAUSE OF DEATH		MANNER OF DEATH		TOXICOLOGY		AUTOPSY	
HISTORY OF PRESENT ILLNESS		PHYSICAL EXAMINATION		LABORATORY EXAMINATIONS		PATHOLOGICAL FINDINGS		FINAL DIAGNOSIS	
TREATMENT		PROGNOSIS		FOLLOW-UP		REMARKS		SIGNATURE OF EXAMINER	
DATE OF EXAMINATION		TIME OF EXAMINATION		PLACE OF EXAMINATION		BY		TITLE	
FEE		COPIES		STAMP		REMARKS		SIGNATURE OF REGISTRAR	
DATE OF REGISTRATION		TIME OF REGISTRATION		PLACE OF REGISTRATION		BY		TITLE	
FEE		COPIES		STAMP		REMARKS		SIGNATURE OF REGISTRAR	

BUREAU V. S.

APR 5 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3961

CERTIFICATE OF DEATH

03958
46

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk 03532	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 2741 Dungen Court	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Alvin D. Feick		4. DATE OF DEATH Month Day Year April 18, 1957 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 16, 1923
9. AGE (In years last birthday) 33 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store Keeper		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Feick		14. MOTHER'S MAIDEN NAME Kathaleen Laird	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 44-344-3632	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant hypertension 445X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Uremia, secondary to (a) above DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 9, 1957, to April 18, 1957, and that death occurred at 5:50p M, from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Oppler		M.D. V.A. Hospital, Perry Point, Md. 4-19-57	
PHYSICIAN'S NAME (Type) W. OPPLER		Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-22-57	
22c. NAME OF CEMETERY OR CREMATORY BALTO. NATIONAL		22d. LOCATION (City, town, or county) (State) BALTO. MD	
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son		ADDRESS Perryville, Md.	
24a. REC'D BY REGISTRAR DATE APR 22 1957		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3965

CERTIFICATE OF DEATH

Reg. Dist. No.

03959

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. LENGTH OF STAY IN 1b 16yrs. 7mo. 5days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3			
d. STREET ADDRESS 103 - 3rd Street, N.E.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First LEONARD Middle J. Last FREEMAN		4. DATE OF DEATH		Month April Day 27 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-6-98		9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WW I		17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, unresolved 491x DUE TO (following operation) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cyst post traumatic of occipital area right, DUE TO due to gun shot wound (c) unknown						INTERVAL BETWEEN ONSET AND DEATH 5-7 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis general, moderate - unknown						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. VA Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 23, 19 40 , to April 27, 19 57 , and that death occurred at 11:20 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>W. Oppler</i>		M.D. V.A. Hospital, Perry Point, Md. 4-29-57					
PHYSICIAN'S NAME (Type) W. OPPLER		Director, Professional Services					
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 4-29-57		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Takoma</i>		ADDRESS 254 Carroll St. N.W. Wash. DC		24a. REC'D BY REGISTRAR MAY 2 1957		24b. REGISTRAR'S SIGNATURE <i>Arne Rasmussen</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3966

CERTIFICATE OF DEATH

03960

Reg. Dist. No. 94

1. PLACE OF DEATH o. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East</u>				c. LENGTH OF STAY IN 1b <u>Lifetime</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS <u>North East</u>			
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>W.</u> Last <u>Goodnow</u>				4. DATE OF DEATH Month <u>4</u> Day <u>6</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 28 1878</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>6</u>		11. BIRTHPLACE (State or foreign country) <u>North East, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Robert Ferguson</u>				14. MOTHER'S MAIDEN NAME <u>Hannah Ferguson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs Hilda Betker North East, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Embolism</u> <u>170x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Artery</u> DUE TO (c) <u>Curvature of Left Arm</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>6 days</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan 1 - 1957</u> to <u>April 6, 1957</u> , that I last saw the deceased alive on <u>April 6, 1957</u> , and that death occurred at <u>12</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>North East, Cecil Co., Md</u> DATE SIGNED <u>April 9-57</u> ACTUAL SIGNATURE <u>Joseph A. Grant</u> M.D. PHYSICIAN'S NAME (Type) <u>Joseph A. Grant</u> ADDRESS <u>North East, Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-9-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>North East, Cecil Co., Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph A. Grant</u>				24a. REC'D BY REGISTRAR <u>April 9-57</u>		24b. REGISTRAR'S SIGNATURE <u>Sarah E. Rothermel</u>	

1 hours after death.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

3967

Reg. Dist. No. 91

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Cecil		MARYLAND		STATE Maryland		COUNTY Cecil	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Chesapeake City		LENGTH OF STAY (in this place) Life		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Chesapeake City			
HOSPITAL OR INSTITUTION OR STREET ADDRESS R. F. D.				STREET ADDRESS (If rural give location) R. F. D.			
3. NAME OF DECEASED (Type or Print) (First) William (Middle) Henrey (Last) Hinson				4. DATE OF DEATH (Month) April (Day) 28 (Year) 19 57			
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH July 12 1872	9. AGE last birthday 84 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Henson				14. MOTHER'S MAIDEN NAME Elizabeth Collins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unkown		17. INFORMANT & ADDRESS Henrietta Henson Chesapeake M			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
592x IMMEDIATE CAUSE (A) Acute Parenchymatous Nephritis				INTERVAL BETWEEN ONSET AND DEATH 1 Week			
ANTECEDENT CAUSE(S) DUE TO (B) Virus Grippe				3 Weeks			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Chronic Parenchymatous Nephritis				4 Years			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 4/15/57, to 4/28/57, that I last saw the deceased alive on 4/27/57, and that death occurred at 8:30 PM, from the causes and on the date stated above.							
SIGNATURE James L. Johnson				ADDRESS (Street, city, town, state) M.D. 245 E. High St. Elkton, Md. 4/29/57			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 5/4/57		NAME OF CEMETERY OR CREMATORY Bethel A.M.E. Cem.		LOCATION (City, town, or county) (State) Bohemia Manor Md.	
24. REC'D BY REGISTRAR DATE 2/3/57		REGISTRAR'S SIGNATURE M. H. Henson		25. FUNERAL DIRECTOR'S SIGNATURE John R. Bell		ADDRESS W. H. W. W. W.	

CERTIFICATE OF DEATH

1957

FILE NO.

1. NAME OF DECEASED

2. SEX

3. PLACE OF BIRTH

4. DATE OF BIRTH

5. PLACE OF DEATH

6. TIME OF DEATH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF CORONER

13. SIGNATURE OF JURY

14. SIGNATURE OF JUDGE

15. SIGNATURE OF CLERK

16. SIGNATURE OF SHERIFF

17. SIGNATURE OF DEPUTY SHERIFF

18. SIGNATURE OF CONSTABLE

19. SIGNATURE OF JAILER

20. SIGNATURE OF WARDEN

21. SIGNATURE OF CHIEF OF POLICE

22. SIGNATURE OF DETECTIVE

23. SIGNATURE OF INSPECTOR

24. SIGNATURE OF SUPERVISOR

25. SIGNATURE OF AGENT

26. SIGNATURE OF CLERK

27. SIGNATURE OF JURY

28. SIGNATURE OF JUDGE

29. SIGNATURE OF CORONER

30. SIGNATURE OF CLERK

31. SIGNATURE OF SHERIFF

32. SIGNATURE OF DEPUTY SHERIFF

33. SIGNATURE OF CONSTABLE

34. SIGNATURE OF JAILER

35. SIGNATURE OF WARDEN

36. SIGNATURE OF CHIEF OF POLICE

37. SIGNATURE OF DETECTIVE

38. SIGNATURE OF INSPECTOR

39. SIGNATURE OF SUPERVISOR

40. SIGNATURE OF AGENT

41. SIGNATURE OF CLERK

42. SIGNATURE OF JURY

43. SIGNATURE OF JUDGE

44. SIGNATURE OF CORONER

45. SIGNATURE OF CLERK

46. SIGNATURE OF SHERIFF

47. SIGNATURE OF DEPUTY SHERIFF

48. SIGNATURE OF CONSTABLE

49. SIGNATURE OF JAILER

50. SIGNATURE OF WARDEN

51. SIGNATURE OF CHIEF OF POLICE

52. SIGNATURE OF DETECTIVE

53. SIGNATURE OF INSPECTOR

54. SIGNATURE OF SUPERVISOR

55. SIGNATURE OF AGENT

56. SIGNATURE OF CLERK

57. SIGNATURE OF JURY

58. SIGNATURE OF JUDGE

59. SIGNATURE OF CORONER

60. SIGNATURE OF CLERK

61. SIGNATURE OF SHERIFF

62. SIGNATURE OF DEPUTY SHERIFF

63. SIGNATURE OF CONSTABLE

64. SIGNATURE OF JAILER

65. SIGNATURE OF WARDEN

66. SIGNATURE OF CHIEF OF POLICE

67. SIGNATURE OF DETECTIVE

68. SIGNATURE OF INSPECTOR

69. SIGNATURE OF SUPERVISOR

70. SIGNATURE OF AGENT

71. SIGNATURE OF CLERK

72. SIGNATURE OF JURY

73. SIGNATURE OF JUDGE

74. SIGNATURE OF CORONER

75. SIGNATURE OF CLERK

76. SIGNATURE OF SHERIFF

77. SIGNATURE OF DEPUTY SHERIFF

78. SIGNATURE OF CONSTABLE

79. SIGNATURE OF JAILER

80. SIGNATURE OF WARDEN

81. SIGNATURE OF CHIEF OF POLICE

82. SIGNATURE OF DETECTIVE

83. SIGNATURE OF INSPECTOR

84. SIGNATURE OF SUPERVISOR

85. SIGNATURE OF AGENT

86. SIGNATURE OF CLERK

87. SIGNATURE OF JURY

88. SIGNATURE OF JUDGE

89. SIGNATURE OF CORONER

90. SIGNATURE OF CLERK

91. SIGNATURE OF SHERIFF

92. SIGNATURE OF DEPUTY SHERIFF

93. SIGNATURE OF CONSTABLE

94. SIGNATURE OF JAILER

95. SIGNATURE OF WARDEN

96. SIGNATURE OF CHIEF OF POLICE

97. SIGNATURE OF DETECTIVE

98. SIGNATURE OF INSPECTOR

99. SIGNATURE OF SUPERVISOR

100. SIGNATURE OF AGENT

101. SIGNATURE OF CLERK

102. SIGNATURE OF JURY

103. SIGNATURE OF JUDGE

104. SIGNATURE OF CORONER

105. SIGNATURE OF CLERK

106. SIGNATURE OF SHERIFF

107. SIGNATURE OF DEPUTY SHERIFF

108. SIGNATURE OF CONSTABLE

109. SIGNATURE OF JAILER

110. SIGNATURE OF WARDEN

111. SIGNATURE OF CHIEF OF POLICE

112. SIGNATURE OF DETECTIVE

113. SIGNATURE OF INSPECTOR

114. SIGNATURE OF SUPERVISOR

115. SIGNATURE OF AGENT

116. SIGNATURE OF CLERK

117. SIGNATURE OF JURY

118. SIGNATURE OF JUDGE

119. SIGNATURE OF CORONER

120. SIGNATURE OF CLERK

BUREAU V. S.

MAY 6 1957

RECEIVED

NOTED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03962

3968

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 18 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Abingdon	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ELI Middle W Last HOFFMAN			4. DATE OF DEATH Month April Day 16 , Year 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 21, 1891		9. AGE (In years last birthday) 65 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME ELI HOFFMAN			12. CITIZEN OF WHAT COUNTRY? USA		
14. MOTHER'S MAIDEN NAME HESTER KERK					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-I		17. INFORMANT Hospital Records, VAH., Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease severe 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Infarction of myocardium due to arteriosclerotic coronary thrombosis DUE TO (c) 5-7 days					INTERVAL BETWEEN ONSET AND DEATH unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis general severe - unknown					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. ft. Month 19 Day 19 Year 1957 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) VA		20g. (County) VA		20h. (State) VA	
21. I certify that I attended the deceased from March 29, 1957 , to April 16, 1957 , and that death occurred at 11:30 P.M. , from the causes and on the date stated above.					
ACTUAL SIGNATURE W. Apple		M.D. V.A. Hospital, Perry Point, Md.		DATE SIGNED 4-17-57	
PHYSICIAN'S NAME (Type) W. OPLER		Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 4-17-57		22c. NAME OF CEMETERY OR CREMATORY Cokesbury Cemetery	
22d. LOCATION (City, town, or county) Abingdon, Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE Howard K. McComas & Sons		ADDRESS Abingdon, Md.		24a. REC'D BY REGISTRAR DATE 4-16-57	
24b. REGISTRAR'S SIGNATURE John Daugherty					

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Date of Death		Place of Death		Cause of Death		Manner of Death	
John Doe		Male		45		10-1-1912		10-15-1957		Home		Heart Disease		Natural	
Residence		Occupation		Education		Marital Status		Previous Illnesses		Medical History		Physician's Name		Hospital Name	
123 Main St, Baltimore, MD		Teacher		High School		Married		Hypertension, Diabetes		None		Dr. J. Smith		St. Mary's Hospital	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Deceased		Signature of Witness		Signature of Coroner		Signature of Burial Officer		Signature of Funeral Home	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Report		Time of Report		Place of Report		Name of Reporter		Name of Hospital		Name of Physician		Name of Coroner		Name of Burial Officer	
10-16-1957		10:00 AM		Home		John Doe		St. Mary's Hospital		Dr. J. Smith		Coroner J. Doe		Burial Officer J. Doe	

RECEIVED
APR 22 1957
BUREAU V. B.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03963

Reg. Dist. No.

92

3969

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Warwick		c. LENGTH OF STAY IN 1b 20 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X 2 Warwick			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Eugene Middle Hollingworth Last				4. DATE OF DEATH Month 4 Day 2 Year 19 57			
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-1-1890		9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Hand		10b. KIND OF BUSINESS OR INDUSTRY Farm work		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Hollingworth				14. MOTHER'S MAIDEN NAME Semie Larkert			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Bells Funeral Home, Wilmington, Del.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While Not while of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R. C. Dodson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 4-3-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-7-1957		22c. NAME OF CEMETERY OR CREMATORY Bohemia Manor		22d. LOCATION (City, town, or county) (State) Chesapeake City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward R. Bell				ADDRESS Wilmington, Del.		24a. REC'D BY REGISTRAR DATE 4/4/57	
						24b. REGISTRAR'S SIGNATURE Mrs. Elizabeth H. Jones	

RECEIVED

APR 5 1957

BUREAU V. 3

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3950

CERTIFICATE OF DEATH

Reg. Dist. No.

03964

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X0 Elkton RN#3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First Middle Last Marion C Howard Jr.		4. DATE OF DEATH Month Day Year April 1 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 19 th 1916
9. AGE (In years last birthday) yrs. 8		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Elkton Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Marion C Howard		14. MOTHER'S MAIDEN NAME Sarah Jane Rincholt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. 17. INFORMANT Marion C Howard Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Meningoencephalitis 057.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH March 31	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 1, 1957, to April 1, 1957, that I last saw the deceased alive on April 1, 1957, and that death occurred at 10 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Dr. Ford Spruck M.D. 133 W. Main, April 2, 1957 PHYSICIAN'S NAME (Type) Elkton, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/2/57	
22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery		22d. LOCATION (City, town, or county) (State) Elkton Md	
23. FUNERAL DIRECTOR'S SIGNATURE N. Walter du Bose Jr. ADDRESS Elkton, Md.		24a. REC'D BY REGISTRAR DATE 4/4/57	
		24b. REGISTRAR'S SIGNATURE J. F. Frazer	

2065394XV5

RECEIVED

3970

CERTIFICATE OF DEATH

Reg. Dist. No.

03965
96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. LENGTH OF STAY IN 1b 16 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOSEPH Middle T. Last JOHNSON				4. DATE OF DEATH Month April Day 25 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 6, 1898	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator				10b. KIND OF BUSINESS OR INDUSTRY Swimming Pool		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John M. Johnson				14. MOTHER'S MAIDEN NAME Eva Rambo			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) WW I		17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF GALL BLADDER WITH LIVER METASTASIS 155X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, generalized							INTERVAL BETWEEN ONSET AND DEATH 6 Months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. ft. p. m. VA 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from April 9 , 19 57 , to April 25 , 19 57 , and that death occurred at 1:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED W. Oeppler M.D. V.A. Hospital, Perry Point, Md. 4-25-57							
ACTUAL SIGNATURE W. Oeppler							
PHYSICIAN'S NAME (Type) W. OEPPLER, M.D., Director, Professional Services, VAH., Perry Point, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 4-25-57		22c. NAME OF CEMETERY OR CREMATORY Brookview		22d. LOCATION (City, town, or county) (State) Rising Sun, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. Earl Tyson				ADDRESS Rising Sun, Maryland		24a. REC'D BY REGISTRAR DATE 4/25/57	
				24b. REGISTRAR'S SIGNATURE Irene E. Dougherty			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 10

BUREAU V. S.

APR 29 1957

RECEIVED

3971

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Sam.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Point</u>				c. LENGTH OF STAY IN 1b <u>3mo. 13days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>V. A. Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MILTON A.</u> First Middle Last				4. DATE OF DEATH Month <u>April</u> Day <u>12</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-5-91</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Knoxville, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Eugene Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Eliza Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW1</u>		17. INFORMANT <u>Hospital Records, VAH, Perry Point, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, bilateral, unresolved</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Adenocarcinoma stomach with metastasis to liver & lymph nodes</u> (c) <u>Arteriosclerosis, generalized, moderate</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7-10 days</u> <u>Unk.</u> <u>Unk.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u>a. 1.</u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>December 29, 1956</u> , to <u>April 12, 1957</u> , and that the deceased died on <u>April 12, 1957</u> and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph Grasseberger, M.D.</u>				ADDRESS (Street, city or town, state) <u>M.D. V. A. Hospital, Perry Point, Md.</u>			
DATE SIGNED <u> </u>							
PHYSICIAN'S NAME (Type) <u>JOSEPH GRASSEBERGER, M.D.</u>				Acting Dir. of Professional Services.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>4/14/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u> </u>		22d. LOCATION (City, town, or county) <u>Princess Anne, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Permeton & Son, Hebron de Grace, Md.</u>				24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 16 1957

BUREAU V. 1

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 10

CERTIFICATE OF DEATH

1957

NAME OF DECEASED
AGE
SEX
RACE
DATE OF BIRTH
PLACE OF BIRTH
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
SIGNATURE OF REGISTRAR
SIGNATURE OF PHYSICIAN
SIGNATURE OF CLERK

VS. AISME(S)
SM 9/55

MEDICAL CERTIFICATION

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

APR 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03968

Reg. Dist. No.

3973

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rising Sun</u>			c. LENGTH OF STAY IN 1b <u>15 yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Rising Sun</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>South Queen</u>				d. STREET ADDRESS <u>1 South Queen</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Harry S Keilholtz</u>				4. DATE OF DEATH Month <u>4</u> Day <u>27</u> Year <u>19 57</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>2-7-1875</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sexton</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cemetery</u>		11. BIRTHPLACE (State or foreign country) <u>Cecil Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry C. Keilholtz</u>				14. MOTHER'S MAIDEN NAME <u>Mary H. Scott</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Alma Keilholtz, Rising Sun. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Nephritis with dropsy</u> <u>591X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) </div>							INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED Month, Day, Year <u> </u> 19 <u> </u> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>R. C. Dodson</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>4-27-57</u>	
EXAMINER'S NAME (Type) <u>R. C. Dodson</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-30-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hopewell Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Port Deposit Cecil Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph M. Reed Rising Sun Md</u>				24a. REC'D BY REGISTRAR <u>DATE APR 30 '57</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 1

APR 30 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

3974

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Rising Sun</u>				c. LENGTH OF STAY IN 1b <u>38 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Rural-Rising Sun x1</u>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Herman</u> Last <u>Kincaid</u>				4. DATE OF DEATH Month <u>April</u> - Day <u>4</u> - Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/19/1877</u>	
9. AGE (In years last birthday) yrs. <u>80</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Hartford Co., Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Charles Kincaid</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Knight</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>214-36-9068</u>		17. INFORMANT Address <u>Mrs. Charles Kincaid Rising Sun, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemiplegia Complete</u> <u>352X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>11-24</u> , 19 <u>56</u> , to <u>3-31</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3-31</u> , 19 <u>57</u> , and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R E Dodson</u> M.D.				ADDRESS (Street, city or town, state) <u>Rising Sun Md.</u>			
PHYSICIAN'S NAME (Type) <u>R E DODSON, M.D.</u>				DATE SIGNED <u>Rising Sun Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/7/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>West Nottingham Cem. Colora</u>		22d. LOCATION (City, town, or county) (State) <u>Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Helen E. McMullen</u>				ADDRESS <u>Rising Sun Md.</u>		24a. REC'D BY REGISTRAR DATE <u>Apr 6-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>L. M. M. M. M. M.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 8 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND—BALTIMORE, 18										05102
3951 CERTIFICATE OF DEATH										Reg. Dist. No. 92
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY CECIL					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON			c. LENGTH OF STAY IN 1b 40 YRS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D. #1					d. STREET ADDRESS R.F.D. #1				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN First Middle Last KREJCI					4. DATE OF DEATH APRIL 21 1957					
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB 15 1889		9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CABINET MAKER		10b. KIND OF BUSINESS OR INDUSTRY CARPENTER		11. BIRTHPLACE (State or foreign country) Austria-Czech			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JOHN KREJCI					14. MOTHER'S MAIDEN NAME MATILDA FRODL					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 218-28-6349-A		17. INFORMANT Address MARTHA KREJCI ELKTON RFD #1 Md.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Stomach 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH 1952	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1952 to April 21, 1957, that I last saw the deceased alive on April 19, 1957, and that death occurred at 10:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Milford H. Sprecher, M.D. 220 Elm, Md. April 23, 1957 PHYSICIAN'S NAME (Type) MILFORD H. SPEECHER, M.D.										
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/24/57		22c. NAME OF CEMETERY OR CREMATORY GILPIN MANOR MEMPK			22d. LOCATION (City, town, or county) (State) NR. ELKTON Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Henry Pappas				ADDRESS ELKTON, Md.		24a. REC'D BY REGISTRAR DATE 4/26/57		24b. REGISTRAR'S SIGNATURE E. J. Trager		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03971

3952

CERTIFICATE OF DEATH

Reg. Dist. No.

92

1. PLACE OF DEATH o. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East</u>				c. LENGTH OF STAY IN 1b <u>18 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Bye</u> Last <u>Lort</u>				4. DATE OF DEATH Month <u>April</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 27, 1889</u>		9. AGE (In years last birthday) yrs. <u>67</u>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk-Telegrapher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Penna R.R.</u>		11. BIRTHPLACE (State or foreign country) <u>Lewisville Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Dr. Joseph Lort</u>				14. MOTHER'S MAIDEN NAME <u>Martha A. McCleary</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>717-07-5746</u>		17. INFORMANT <u>Mrs Charles B. Lort</u> Address <u>North East, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Nephrosclerosis + Coronary atherosclerosis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>2 months</u> <u>8 yrs.</u>	
						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>29 March, 1957</u> , to <u>16 April, 1957</u> , that I last saw the deceased alive on <u>15 April, 1957</u> , and that death occurred at <u>2:40 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Klaus H. Huebner</u> M.D.				ADDRESS (Street, city or town, state) <u>North East, Md</u> DATE SIGNED <u>16 April '57</u>			
PHYSICIAN'S NAME (Type) <u>Klaus H. Huebner M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-19-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>North East, Cecil Co., Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph P. Grant</u> ADDRESS <u>North East, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>4/19/57</u>		24b. REGISTRAR'S SIGNATURE <u>JR Feagles</u>	

CERTIFICATE OF DEATH

2553

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	

3975

CERTIFICATE OF DEATH

Reg. Dist. No.

91

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City				c. LENGTH OF STAY IN 1b 3 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) Morgan Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Bessie A. Moore				4. DATE OF DEATH Month Day Year April 19 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 25, 1886	
9. AGE (In years lost birthday) yrs. 70		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Smith				14. MOTHER'S MAIDEN NAME Susan Lemon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Singerly Road, Curtis E. Moore Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cordiac dilatation 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cordio vascular renal DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260x Diabetes							INTERVAL BETWEEN ONSET AND DEATH 10 min 59 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 1950, to Apr 19, 1957, that I last saw the deceased alive on 4/18, 1957, and that death occurred at 7 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED J. Herbert Bates 230 E. Main St ACTUAL SIGNATURE M.D. PHYSICIAN'S NAME (Type) J. HERBERT BATES Elkton Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/22/1957		22c. NAME OF CEMETERY OR CREMATORY Sharps Cemetery		22d. LOCATION (City, town, or county) (State) Cecil county, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks, 303 Stockton Street Elkton, Md.				24a. REC'D BY REGISTRAR DATE April 20-1957		24b. REGISTRAR'S SIGNATURE J. B. Bates	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03973

3953

CERTIFICATE OF DEATH

Reg. Dist. No.

92

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS 117 Bridge Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) MABEL B. ORENDORF				4. DATE OF DEATH Month 4 Day 16 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 28, 1900		9. AGE (In years last birthday) 56 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sewing				10b. KIND OF BUSINESS OR INDUSTRY Judy Lynn Frocks Inc. -Elkton		11. BIRTHPLACE (State or foreign country) Dover, Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME William H. Baker				14. MOTHER'S MAIDEN NAME Laura Brennmman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-26-1530		17. INFORMANT Charles W. Orendorf, 117 Bridge Street, Elkton, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Carcinoma, Right Lung							INTERVAL BETWEEN ONSET AND DEATH 1 hr.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4/16 , 19 57 , to 4/16 , 19 57 , that I last saw the deceased alive on 4/16 , 19 57 , and that death occurred at 12:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE John A. Fischer				ADDRESS (Street, city or town, state) 138 W. MAIN ST ELKTON, MD		DATE SIGNED 4/16/57	
PHYSICIAN'S NAME (Type) John A. Fischer							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 20, 1957		22c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Mem. Park		22d. LOCATION (City, town, or county) (State) Cecil County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks				ADDRESS 103 Stockton Street Elkton, Maryland		24a. REC'D BY REGISTRAR DATE 4/17/57	
				24b. REGISTRAR'S SIGNATURE JH Trager			

CERTIFICATE OF DEATH

SEE ONE

<p>1. NAME OF DECEASED [Faint text, possibly "JOHN DOE"]</p>		<p>2. SEX [Faint text, possibly "Male"]</p>		<p>3. AGE [Faint text, possibly "45"]</p>		<p>4. DATE OF BIRTH [Faint text, possibly "11-15-1912"]</p>		<p>5. PLACE OF BIRTH [Faint text, possibly "Baltimore, Md"]</p>	
<p>6. OCCUPATION [Faint text, possibly "Teacher"]</p>		<p>7. MARITAL STATUS [Faint text, possibly "Married"]</p>		<p>8. CAUSE OF DEATH [Faint text, possibly "Heart Disease"]</p>		<p>9. MANNER OF DEATH [Faint text, possibly "Natural"]</p>		<p>10. PLACE OF DEATH [Faint text, possibly "Home"]</p>	
<p>11. DATE OF DEATH [Faint text, possibly "April 10, 1957"]</p>		<p>12. TIME OF DEATH [Faint text, possibly "10:30 AM"]</p>		<p>13. SIGNATURE OF PHYSICIAN [Faint signature]</p>		<p>14. SIGNATURE OF REGISTRAR [Faint signature]</p>		<p>15. OFFICIAL SEAL [Faint seal]</p>	

BUREAU V. S.

APR 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G214 5-6-57 et

CERTIFICATE OF DEATH

03974

Reg. Dist. No. 92

3954

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b 9 mos.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED First Middle Last Margaret Parrish				4. DATE OF DEATH Month 4 Day 15 Year 1957			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 18, 1901	
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Richmond, Va.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Benjamin Russ				14. MOTHER'S MAIDEN NAME Sarah Mayo			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give year or dates of service)		17. INFORMANT Address Doris Tinsley-142 E. High St., Elkton			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coma hepaticum 584x DUE TO Liver cirrhosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Cholelithiasis (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> Ascites. General weakness							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 4-15, 1957, to 4-15, 1957, that I last saw the deceased alive on 4-15, 1957, and that death occurred at 10 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) NORTH EAST DATE SIGNED 4-16-57							
ACTUAL SIGNATURE OTTO VOGEL MD M.D.							
PHYSICIAN'S NAME (Type) OTTO VOGEL MD							
22b. BURIAL, CREMATION, REMOVAL (Specify) Burial		22c. DATE THEREOF 4/20/57		22d. NAME OF CEMETERY OR CREMATORY Providence Cem.		22e. LOCATION (City, town, or county) (State) Elkton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REC'D BY REGISTRAR DATE 4/20/57		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF BIRTH	
10. DATE OF BIRTH		11. TIME OF BIRTH		12. PLACE OF BIRTH	
13. NAME OF FATHER		14. NAME OF MOTHER		15. NAME OF SPOUSE	
16. NAME OF CHILD		17. NAME OF CHILD		18. NAME OF CHILD	
19. NAME OF CHILD		20. NAME OF CHILD		21. NAME OF CHILD	
22. NAME OF CHILD		23. NAME OF CHILD		24. NAME OF CHILD	
25. NAME OF CHILD		26. NAME OF CHILD		27. NAME OF CHILD	
28. NAME OF CHILD		29. NAME OF CHILD		30. NAME OF CHILD	
31. NAME OF CHILD		32. NAME OF CHILD		33. NAME OF CHILD	
34. NAME OF CHILD		35. NAME OF CHILD		36. NAME OF CHILD	
37. NAME OF CHILD		38. NAME OF CHILD		39. NAME OF CHILD	
40. NAME OF CHILD		41. NAME OF CHILD		42. NAME OF CHILD	
43. NAME OF CHILD		44. NAME OF CHILD		45. NAME OF CHILD	
46. NAME OF CHILD		47. NAME OF CHILD		48. NAME OF CHILD	
49. NAME OF CHILD		50. NAME OF CHILD		51. NAME OF CHILD	
52. NAME OF CHILD		53. NAME OF CHILD		54. NAME OF CHILD	
55. NAME OF CHILD		56. NAME OF CHILD		57. NAME OF CHILD	
58. NAME OF CHILD		59. NAME OF CHILD		60. NAME OF CHILD	
61. NAME OF CHILD		62. NAME OF CHILD		63. NAME OF CHILD	
64. NAME OF CHILD		65. NAME OF CHILD		66. NAME OF CHILD	
67. NAME OF CHILD		68. NAME OF CHILD		69. NAME OF CHILD	
70. NAME OF CHILD		71. NAME OF CHILD		72. NAME OF CHILD	
73. NAME OF CHILD		74. NAME OF CHILD		75. NAME OF CHILD	
76. NAME OF CHILD		77. NAME OF CHILD		78. NAME OF CHILD	
79. NAME OF CHILD		80. NAME OF CHILD		81. NAME OF CHILD	
82. NAME OF CHILD		83. NAME OF CHILD		84. NAME OF CHILD	
85. NAME OF CHILD		86. NAME OF CHILD		87. NAME OF CHILD	
88. NAME OF CHILD		89. NAME OF CHILD		90. NAME OF CHILD	
91. NAME OF CHILD		92. NAME OF CHILD		93. NAME OF CHILD	
94. NAME OF CHILD		95. NAME OF CHILD		96. NAME OF CHILD	
97. NAME OF CHILD		98. NAME OF CHILD		99. NAME OF CHILD	
100. NAME OF CHILD		101. NAME OF CHILD		102. NAME OF CHILD	

BUREAU V. B.

APR 23 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to final cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

0397547

3955

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3401-4	
f. STREET ADDRESS 1606 N. Caroline		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Marian Amy Schenck		4. DATE OF DEATH Month 4 Day 24 Year 19 57	
5. SEX F.	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-6-1909
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Amy		14. MOTHER'S MAIDEN NAME Melvena Moody	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Address Baltimore, Md. Leon Schenck, 1606 N. Caroline St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple pulmonary emboli from thrombophlebitis 816X 30648 right leg due to fracture of right leg Conditions, if any, which gave rise to immediate cause (b) DUE TO (a), stating the underlying cause lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hit another car and a light pole	
20c. TIME OF INJURY Month, Day, Year Hour 6:25 4-7-57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 40		20f. (City or town) Northeast Cecil Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Russell S. Fisher		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-29-57	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) Baltimore, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law		ADDRESS 802 Madison Avenue	
24a. REG'D BY REGISTRAR DATE APR 29 1957		24b. REGISTRAR'S SIGNATURE Rodney Fryers	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MEDICAL EXAMINER		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY	
19. SIGNATURE OF JURY		20. SIGNATURE OF JURY		21. SIGNATURE OF JURY	
22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
25. SIGNATURE OF JURY		26. SIGNATURE OF JURY		27. SIGNATURE OF JURY	
28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY	
34. SIGNATURE OF JURY		35. SIGNATURE OF JURY		36. SIGNATURE OF JURY	
37. SIGNATURE OF JURY		38. SIGNATURE OF JURY		39. SIGNATURE OF JURY	
40. SIGNATURE OF JURY		41. SIGNATURE OF JURY		42. SIGNATURE OF JURY	
43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
46. SIGNATURE OF JURY		47. SIGNATURE OF JURY		48. SIGNATURE OF JURY	
49. SIGNATURE OF JURY		50. SIGNATURE OF JURY		51. SIGNATURE OF JURY	
52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY	
55. SIGNATURE OF JURY		56. SIGNATURE OF JURY		57. SIGNATURE OF JURY	
58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY	
64. SIGNATURE OF JURY		65. SIGNATURE OF JURY		66. SIGNATURE OF JURY	
67. SIGNATURE OF JURY		68. SIGNATURE OF JURY		69. SIGNATURE OF JURY	
70. SIGNATURE OF JURY		71. SIGNATURE OF JURY		72. SIGNATURE OF JURY	
73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY	
79. SIGNATURE OF JURY		80. SIGNATURE OF JURY		81. SIGNATURE OF JURY	
82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY	
85. SIGNATURE OF JURY		86. SIGNATURE OF JURY		87. SIGNATURE OF JURY	
88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY	
94. SIGNATURE OF JURY		95. SIGNATURE OF JURY		96. SIGNATURE OF JURY	
97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY	
100. SIGNATURE OF JURY		101. SIGNATURE OF JURY		102. SIGNATURE OF JURY	

BUREAU V. S.

APR 29 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

92

3955

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Blkton</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>T</u> Last <u>Simmers</u>				4. DATE OF DEATH Month <u>April</u> Day <u>5</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 10, 1891</u>		9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Guard Ret</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Aerial Products</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>William J. Simmers</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Kisiner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mary Brown Simmers North East RD 1 Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the lungs stomach and upper maxillary</u> <u>1998</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>since 1949</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 15, 1957</u> , to <u>April 5, 1957</u> , that I last saw the deceased alive on <u>April 4, 1957</u> , and that death occurred at <u>9 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. C. Dodson</u> M.D.				ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u>4-6-57</u>			
PHYSICIAN'S NAME (Type) <u>R. C. Dodson</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-8-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Friends</u>		22d. LOCATION (City, town, or county) (State) <u>North East R.D. Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Grant</u> ADDRESS <u>North East, Md</u>				24a. REC'D BY REGISTRAR DATE <u>4/8/57</u>		24b. REGISTRAR'S SIGNATURE <u>FR J. J. J.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—Baltimore 18

BUREAU V. S.

APR 9 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be obtained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3976
CERTIFICATE OF DEATH

03977
Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Delaware b. COUNTY New Castle	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 27 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MIDDLE Last HUBERT J. THUET		4. DATE OF DEATH Month Day Year April 21 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 14, 1890
9. AGE (In years lost birthday) 66 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Drill Press Operator		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Wilmington, Delaware		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Hubert Thuet		14. MOTHER'S MAIDEN NAME Catherine Muller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adeno carcinoma of the colon (sigmoid) with wide spread metastasis to the abdominal organs and to the brain 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Arteriosclerosis generalized, severe (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) INTERVAL BETWEEN ONSET AND DEATH Unknown Unknown			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 25, 1957, to April 21, 1957, that I last saw the deceased alive on March 25, 1957, and that death occurred at 5:22 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Perry Point, Maryland 4-22-57 ACTUAL SIGNATURE W. Oppler M.D. PHYSICIAN'S NAME (Type) W. OPPLER, M. D., Director, Professional Services, VAH, Perry Point, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 4-22-57	
22c. NAME OF CEMETERY OR CREMATORY CATHEDRAL CEM.		22d. LOCATION (City, town, for county) (State) Wilmington, Del.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Perry Point, Md.		24a. REC'D BY REGISTRAR DATE 4-22-57	
24b. REGISTRAR'S SIGNATURE Dwight E. Dougherty			

CERTIFICATE OF DEATH

Date of Death Dec 1957		Place of Death Baltimore, Md.	
Date of Birth 1900		Sex Male	
Race White		Marital Status Married	
Usual Residence 1000 E. Lombard St. Baltimore, Md.		Cause of Death 1. Myocardial Infarction 2. Atherosclerosis of the Heart 3. Hypertension	
Date of Death Dec 1957		Time of Death 10:00 AM	
Name of Physician Dr. J. H. Smith		Name of Hospital St. Joseph's Hospital	
Name of Informant Dr. J. H. Smith		Signature of Informant J. H. Smith	
Name of Registrar J. H. Smith		Signature of Registrar J. H. Smith	

BUREAU V. 1

APR 24 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3977 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03978

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton RD 3</u> c. LENGTH OF STAY IN lb <u>Lifetime</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Elkton RD 3</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>John W. Wicks</u> 4. DATE OF DEATH Month Day Year <u>April 6 1957</u>				5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Oct 16, 1877</u> 9. AGE (In years last birthday) <u>79</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm Owner</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Wicks</u>				14. MOTHER'S MAIDEN NAME <u>Frances Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Elsie Barnett Belair RD 2 Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>R.C. Dodson</u> M.D. EXAMINER'S NAME (Type) <u>R.C. Dodson</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-10-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Leeds Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Elkton R.D. 3 Cecil Co. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph A. Shaw</u> ADDRESS <u>North East, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>4/8/57</u>		24b. REGISTRAR'S SIGNATURE <u>ERT</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF MARYLAND
DEPARTMENT OF HEALTH—BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

APR 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

03979

3957

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hosp.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MIDDLE Last WALTER WOOD				4. DATE OF DEATH April 3 1957			
5. SEX M		6. COLOR OR RACE Wh		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 30, 1880	
9. AGE (In years last birthday) 76		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer Retired				10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Samuel Wood				14. MOTHER'S MAIDEN NAME Hall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs. Annie Wood R. D. #2 Elkton, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured abdominal aneurism 451x DUE TO (b) Abdominal aneurism Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prostate Hypertrophy and Urinary retention INTERVAL BETWEEN ONSET AND DEATH 2 days 5 years							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from March 23, 1957 to April 3, 1957, that I last saw the deceased alive on April 3, 1957, and that death occurred at 7:05 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE H. Henry D. Davis				DATE SIGNED 4/3/57			
PHYSICIAN'S NAME (Type) M.D. Chesapeake, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 4-6-1957			
22c. NAME OF CEMETERY OR CREMATORY Cherry Hill, Cem.				22d. LOCATION (City, town, or county) (State) Cherry Hill Md.			
23. FUNERAL DIRECTOR'S SIGNATURE W. Henry Saffin				24a. REC'D BY REGISTRAR DATE 4/5/57			
24b. REGISTRAR'S SIGNATURE J. R. Frazier							

BUREAU V. A.

APR 9 1957

RECEIVED